DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

APPLICATION FOR FREE STANDING SURGICAL CENTER LICENSE

FACILITY NAME _____
Print

FACILITY ADDRESS _____
ADDRESS 1

_____
ADDRESS 2

_____ _____ _____
CITY STATE ZIP CODE

ADMINISTRATOR/CEO _____
Print

MEDICAL DIRECTOR _____
Print

M.D. License #:_____ Exp. Date:_____

DIRECTOR OF NURSING _____
Print

R.N. License #:_____ Exp. Date:_____

FACILITY CONTACT _____
Print Name and Title

PHONE NUMBERS _____ _____ _____
FACILITY PHONE NUMBER CONTACT PHONE NUMBER CONTACT FAX

Facility Type
PLEASE PRINT

☐ Single Specialty Identify:_____

☐ Multi-Specialty (list)

_____

Please complete the following section using the square footage requirements of the Design and Construction Guidelines in use at the time of initial licensure as well as the "American College of Surgeons Classes of Surgical Facilities". If there is ambiguity or conflict, prior written clarification from this office is required.

		NUMBER OF CLASS A OPERATING ROOMS/ PROCEDURE ROOMS	
TOTAL NUMBER OF PREP/RECOVERY BEDS (DUAL USE)		NUMBER OF CLASS B OPERATING ROOMS	
TOTAL NUMBER OF OF PREP BEDS		NUMBER OF CLASS C OPERATING ROOMS	
TOTAL NUMBER RECOVERY BEDS		TOTAL NUMBER OF OPERATING ROOMS	

ACCREDITED? ☐ YES BY WHOM: _____
Include effective expiration dates per agency _____
_____

☐ NO

PLEASE ATTACH THE MOST CURRENT COPY OF THE FOLLOWING:

1. A LIST SHOWING THE NAMES AND ADDRESSES OF EACH OFFICER, DIRECTOR, AND OWNER HAVING TEN (10) PERCENT OR MORE INTEREST IN THE FACILITY.
2. A LIST SHOWING THE NAMES AND ADDRESSES OF THE GOVERNING BODY, IF DIFFERENT FROM THE PRECEDING GROUP.
3. ACCREDITING AGENCY(IES) CERTIFICATE(S)
4. ACCREDITING AGENCY(IES) REPORT(S)
5. FIRE SAFETY REPORT
6. FOR RE-LICENSURE: PHONE DIRECTORY (INCLUDE EMAIL ADDRESSES IF AVAILABLE TO OHFLC FOR USE)
7. OTHER:_____

NAME OF PERSON COMPLETING THIS FORM:_____
PRINT

SIGNATURE:_____ TITLE:_____

DATE:_____

CHECKS SHOULD BE MADE PAYABLE TO: **DELAWARE DIVISION OF PUBLIC HEALTH**

INITIAL APPLICATION FEE:	ANNUAL LICENSURE FEE:
$250.00	$150.00

PLEASE COMPLETE AND RETURN APPLICATION WITH LICENSURE FEE TO
OFFICE OF HEALTH FACILITIES LICENSING & CERTIFICATION
2055 LIMESTONE ROAD
SUITE 200
WILMINGTON DE 19808

03/06